REGISTRATION

FACILITY: REDOAK HOSPITAL, 17400 Red Oak Dr., Houston, Tx Tel: (281)919-1712 Fax:(832)446-9661

Date 3-18-1	Home Phone Work	Phone	∕Email				
Patient Last Name	First Na	-	J				
Street Address							
City Spain	9	State Texas	Zip 77323				
Sex ZM GF	Age_ Birth date Single Single	Married □ Widowed					
Social Security #		Driver's Lice	ense #				
Insured NameLas	How and when First Name Initial	e did you learn about this	s Hospita				
Relationship To Ins		□ Chile	d □ Other				
Condition/Illness R	•	□ Auto	— -				
	Company Name ATIT		Occupation outside Test				
EMPLOYER	Address Sareho 51.	Phone	☐ Full-time ☐ Part-time				
	City Houston State TY	Zip	Years Employed 349				
	Name	Birthdate	SSN:				
INSURED	Last Name First Name Initial						
INFORMATION	Employer Na	Y	ears Employed				
10000	Address Phone	c	occupation				
, in the state of	City State	Zip	☐ Full-time ☐ Part-time				
PATIENT	Please list any and all insurance and/or employee	health care plan coverag	e you or your spouse may have				
INSURANCE	Insurance Company or Health Care Plan Name_						
INFORMATION	Policy/Group #:		e Date:				
· · · · · · · · · · · · · · · · · · ·	Name of Insured:	ID #:					
SPOUSE	Please list any and all coinsurance and/or employ	ee health care plan cover	age you or your spouse may have				
COINSURANCE	Insurance Company or Health Care Plan Name_						
INFORMATION	Policy/Group #:		e Date:				
	Name of Insured:	ID#:_					
	Are your present symptoms or conditions rela						
	or other personal injury someone else might be	legally liable for? U Yes	M No Your Initials:				
MEDICAL	If you answered yes, please fill out accident specific form, available at the front desk.						
AND LEGAL	Pregnant Yes No Pacemaker Yes		an				
INFORMATION	Person to contact in emergency (Name and Phone #) Attorney Telephone:						
	Attorney Address		cphone				
	Legal Assignment Of Benefits And Designation Of	Authorized Representative	2				
	In considering the amount of medical expenses to	be incurred, I, the unders	signed, have insurance and/or employee				
•	health care benefits coverage with the above caption	ned, and hereby assign ar	nd convey directly to the above named				
	healthcare provider(s), as my designated Autho	rized Representative(s), a	Il medical benefits and/or insurance				
Patient	reimbursement, if any, otherwise payable to me for se managed care network participation status. I understa	rvices rendered from such p	provider(s), regardless of such provider's				
Agreement	applicable insurance or benefit payments. I hereb	v authorize the above nat	med provider(s) to release all medical				
&	information necessary to process my claims under HI	PAA. I hereby authorize an	y plan administrator or fiduciary, insurer				
Authorization	and my attorney to release to such provider(s) any and	l all plan documents, insura	nce policy and/or settlement information				
For The Release	upon written request from such provider(s) in order	upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable					
Of Medical And	remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.						
Health Plan	I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have						
Documents For	to such group health plans, health insurance issuer	s or tortfeasor insurer(s) u	inder any applicable insurance policies,				
The Claims	employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I						
Processing & Reimbursement	received from the above named provider(s), and to the full extent permissible under the law or						
As Required by	benefits, settlement, insurance reimbursement and any applicable reme						
Federal and State	information about the claim to the same extent as the or law; (4) making any request, or giving, or receiving		00.0				
Laws	judicial actions by such provider(s) to pursue such	laim, chose in ac	03/18/14 KINI/SSS				
	group health plan(s), including, if necessary, bring	suit by such prov. ADMII:	OKHON KOZHAYA VISIT #: 2562				
	group health plan in my name with derivative standing	g but at such prov MR# 10	0304				
	is valid for all administrative and judicial reviews und	er PPACA, ERISA _{-IMMUM}	mumilippicable federal or state laws. A				
	photocopy of this assignment is to be considered as ve	iia as the original. I have re	ead and rully understand this agreement.				
3. % - 3. - 3. %			3-18-14				
	Signature of Insured / Guardian		Date				

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REGISTRATION

FACILITY: REDOAK HOSPITAL, 17400 RedOak Dr, Houston, Tx Tel: (281)919-1712 Fax: (832)446-8961

Date 2-5-/	7 Cell Home Phone	W	ork Phone	Er	nail '	
Patient Last Name		First Name		Initial	\mathcal{D}^{\top}	
Street Address					*	
City / Jouston			State_/X_		77067	<u></u>
Sex (F)		Single	(Married)	Widowed	Separated	Divorced
Social Security #				Driver's License #		
Insured Name	ast Name First Name	How and wa	here did you lea	rn about this Hosp	11417	
		Spouse		Child		Other
Relationship To In Condition/ Illness l		-	nent	Auto		Other
Condition/ imiess r	Company Name		IOM		cupation	<u> </u>
EMPLOYER	Address 201	Last.	Phone		Full-time	Part-time
EMPLOIER	City	State	Zi	p Year	rs Employed	<u></u>
<u> </u>	Name	/\	Birthda		SN:	
SPOUSE	Last Name	First Name Ini	****************			
(PARENT)	Employer Name &	aulilo		Years E	mployed	
(111011)	Address	Phone		Occupa		
	City	State	Zip	-	Full-time	Part-time
PATIENT	Please list any and all it	surance and/or employ	yee health care 1	olan coverage you	or your spouse:	may have
INSURANCE	Insurance Company or	Health Care Plan Nam	ellniteel	Lealthcon		
INFORMATION	Policy/Group #: 725	1266		Effective Date	:	
	Name of Insured:	1				
SPOUSE	Please list any and all co			e plan coverage yo	ou or your spous	e may have
COINSURANCE	Insurance Company or I	Health Care Plan Name	e			
INFORMATION	Policy/Group #:			_ Effective Date:		
	Name of Insured: ID #:					
	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? Ves No Your Initials:					
	or other personal injur	y someone else might	be legally mable	his at the front dea	Your Initials	··
MEDICAL	If you answered yes, please fill out accident specific form, available at the front desk.					
AND LEGAL	Pregnant Yes (No) Pacemaker Yes (No) Family Physician Person to contact in emergency (Name and Phone #)					
INFORMATION	Attorney Telephone:					
	Address			rotophon	· <u> </u>	 .
		efits And Designation (of Authorized Re	presentative		
	Legal Assignment Of Benefits And Designation Of Authorized Representative In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee					
	health care benefits cover	age with the above cap	tioned, and herel	by assign and conv	ey directly to th	e above named
	healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance					
Patient	reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's					
Agreement	managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical					
~ &	information necessary to pr	rocess my claims under I	IIPAA, I hereby	authorize any plan a	dministrator or fi	duciary, insurer
Authorization	and my attorney to release	to such provider(s) any a	nd all plan docun	nents, insurance pol-	icy and/or settlem	ent information
For The Release	upon written request from	such provider(s) in ord	er to claim such	medical benefits, r	eimbursement or	any applicable
Of Medical And	remedies. I authorize the us	e of this signature on all	my insurance and	or employee health	benefits claim su	bmissions.
Health Plan	I hereby convey to the a employee group health plan	bove named provider(s),	to the full extent	permissible under i	ne law and under	any applicable
Documents For	to such group health plan	i(s), insurance poneies o e health insurance issue	r naonny ciami, ers or tortfeasor	any ciann, chose m insprer(s) under an	action, or other inst	prance policies.
The Claims	employee benefits plan(s) of	or public policies with res	spect to medical e	xpenses incurred as	a result of the me	edical services I
Processing &	received from the above na	med provider(s), and to	he full extent per	missible under the l	aw to claim or lie	n such medical
Reimbursement	benefits, settlement, insurar	ice reimbursement and a	ny applicable i		** * *	ning
As Required by	information about the claim	to the same extent as the	e assignor; (2)		2014	l 02 05 facts
Federal and State	or law; (4) making any requ			106047	2014	1-02-05 and
Laws .	judicial actions by such property health plan(a), inclu-			R196047	.	oyee oyee
	group health plan(s), inclu- group health plan in my nai	unig, ii necessary, uning ne with derivative standi	ng but at such	952-08-19	291627	nent
·	is valid for all administrativ	e and judicial reviews un	der PPACA, l			s. A
	photocopy of this assignmen	nt is to be considered as v	alid as the origin	al. I have read and f	ully understand th	
			~			
				<u></u>	Date Date	
	Signature of Insured	/ Guardian			Date	· [
	Signature of mented	/ Guardian			Date	

Case 4:16-cv-01542 Document 7-3 Filed in TXSD on 07/12/16 Page 3 of 3 **REGISTRATION**

FACILITY: REDOAK HOSPITAL, 17400 RedOak Dr, Houston, Tx Tel: (281)919-1712 Fax: (832)446-9661

1 1241		Wor	rk Phone	Email		
Date (8 / 7	Home Phone	First Name	R I Hone	Initial		
Patient Last Name		rust rame				
Street Address		. , ,	State Tre	x4.5 Zip 7	7388	
City Spring	e Birth date	Single		☐ Widowed ☐ Separ	rated Divorced	
Sex DM DF Ag	e Biriii daic			Driver's License #		
Social Security #		How and wh	ere did you le	arn about this Hospita		
Insured Name	Name First Name	Initial			□ Other	
Relationship To Insur		Spouse		□ Child	□ Other	
Condition/ Illness Rel	ated To Illness	□ Employm	ent	□ Auto		
CONMITON MARGOR 144	Company Name			Occupa		
A CONTRACTOR OF	Address		Phone			
The state of the s	City	State		Zip Years En	ipioyed	
The Party of the State of the Control of the Contro	Name		Birtho	ateSSN:_		
	Last Name	First Name Ini	tial	Years Emplo	beved	
FEATREE TE	Employer Name			Occupation		
	Address .	Phone_	7:	Occupation_	1-time	
	City	State	Zip	-1		
5	City Please list any and all inst	urance and/or emplo	yee health car	fealth car	e j	
	Insurance Company of He	ealth Care Plan Nan	ne Unique	Effective Date:		
The second second	Policy/Group #: 72	2200			198 299	
			V- 1 141 .	ID#.	r vour spouse may have	
	Name of Insured: / Please list any and all coi	nsurance and/or em	ployee health o	are plan coverage you o	r your spoule zzy	
	Insurance Company or H	ealth Care Plan Nan	ne	Effective Date:		
1000	Policy/Group #:			TD #+		
	Name of Insured:			μπ.	ident, work-related injury Your Initials:	
	Are your present sympt	oms or conditions	related to or t	the feed of the other	Your Initials:	
200	· · · · · · · · · · · · · · · · · · ·	TOWN ACTION AICA MICH	it ne ieoviliv liz	INE IOI: LIKE EITO	1001 1111111111111111111111111111111111	
1	If you answered ves, pleas	se fill out accident sp	ecinc ioim, av	Family Physician		
	Pregnant Yes No	Pacemaker DY	es ⊔ No J	amily Physician		
TO THE RE	Person to contact in emer	rgency (Name and F	none #)	Telephone:		
	Attorney			rerephone		
	Address		OCA -thereime	Dannesantativa		
	Legal Assignment Of Ben	efits And Designation	of Authorized	ed I the undersigned has	ve insurance and/or employee	
	In considering the amou	mt of medical expens	captioned and	hereby assign and convey	directly to the above named	
	health care benefits cover	s my designated A	uthorized Rep	resentative(s), all medica	al benefits and/or insurance provider's	
Section 1	reimbursement if any, other	erwise payable to me	for services reno	dered from such provider(s)), regardless of such provider's or all charges regardless of any	
Patient						
Agreement	applicable insurance or b	enefit payments. I h	nereby authoriz	the above named provi	ider(s) to release all medical	
&						
-Authorization	and my attorney to release	to such provider(s) ar	ly and an plan o	such medical benefits, rei	mbursement or any applicable	
For The Release	upon written request from remedies. I authorize the u	such provider(s) in	all my insurance	and/or employee health be	enefits claim submissions.	
Of Medical And	remedies. I authorize the u					
THE THEFT	emplo					
Documents For	to suc	•	tortfe	agor ingiliter(s) linder ally	applicable manage poneres,	
The Claims	emple	2014-01-10	o med	ical expenses incurred as a	result of the medical services I w to claim or lien such medical	
Processing &	receiv R19602495	01 10	l exte	a remedies including but	are not limited to, (1) obtaining	
Remoursement	benef 1952-01-28	200000	mor (2) submitting evidence: (3)) making statements about facts	
Ackennier by	inton	288606	· motio	a about anneal proceedings	and (5) any administrative and	
Pedical and Sain	or law, (-)	rovider(s) to musue	n aha	e in action or right agains	st any liable party or employee	
Lates	or law, (7) means of law, (7) means of law, (7) means of law, (8) means of law, (9)					
	group health plan(s), including, if necessary, oring suit by such provider(s) expenses. Unless revoked, this assignment group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment					
	group health plan in my name with derivative standing but at such provided of the standard of					
	photocopy of this assignm	ent is to be considered	as valid as the	original. I have read and it	my unucisiand uns agreement	
	5/			}-	-8-14	
	X				Date /	
	Signature of Insure	d / Guardian				
The state of the s	57				50	